New Jersey Office of the Attorney General
Division of Consumer Affairs
Drug Control Unit
124 Halsey Street, 3rd Floor, P.O. Box 45045, Newark, NJ 07101
(973) 504-6351

Controlled Dangerous Substance Registration

Reinstatement Application
Instruction sheet

Complete the reinstatement application if your C.D.S. registration has been in expired status for more than 30 days. If your C.D.S. registration has been in expired status for fewer than 30 days, you can renew online at https://newjersey.mylicense.com or you can call 973-273-8090 to request a paper renewal application or to get your mylicense password (to renew online).

A New Jersey C.D.S. registration is issued only for a New Jersey location. Be sure to include a check or money order, in the correct amount, payable to the "State of New Jersey." It will take 4-6 weeks to process this application. Your C.D.S. registration will be mailed to the mailing address on file with your professional licensing board.

Please note:

1. A reinstatement application must be completed by any Dispenser/Prescriber/Practitioner or Mid-Level Dispenser/Prescriber/Practitioner whose C.D.S. registration has expired or become inactive. An active D.E.A. registration for an address which corresponds with a New Jersey C.D.S. registration is also required. If your D.E.A. registration has expired or is inactive, contact the U.S. Drug Enforcement Administration, 80 Mulberry Street, Newark, New Jersey 07102, (1-888-356-1071) or at *www.deadiversion.usdoj.gov*.

2. Reinstatement fee: If your C.D.S. registration is in an "inactive" status or it expired within the past 12 months, the Reinstatement/ Renewal fee is $20.00. If it expired more than 12 months ago, you must contact the Drug Control Unit for the correct fee amount.

3. In order to complete the attached application, please note:

   a. A dispenser/prescriber/ practitioner includes medical doctors, doctors of osteopathy, dentists, optometrists, veterinarians, and podiatrists. A mid-level dispenser/prescriber/practitioner includes physician assistants, advanced practice nurses and certified nurse midwives. Pharmacies must complete a separate application.
   b. Every person or firm handling controlled dangerous substances in New Jersey is required to have both a state and federal registration for that purpose. Federal facilities **do not** require registration.
   c. The address supplied must be current and an actual location where controlled dangerous substances will be stored, prescribed, dispensed, etc. **The address cannot be solely a post office box.**
   d. Dentists and optometrists may only register at an address for which they hold a current registration issued by their board and at which the C.D.S. registration is required pursuant to 3(c) above.
   e. Individual practitioner applicants (medical doctors, dentists, optometrists, veterinarians, etc.) must use their own name, not professional association/corporation or partnership information.
   f. Pharmacies are required to use their common trading name (e.g. David Pharmacy), not a business or corporate name.
   g. Dispensers/prescribers/practitioners must have an active and current New Jersey professional license number.
   h. Optometrists may prescribe or dispense only Schedule III, IV or V controlled dangerous substances.

   - **Advanced Practice Nurses may prescribe controlled dangerous substances, but may not purchase or maintain any stock supplies of any C.D.S. medication.**

4. To check the status of your reinstatement application, call (973)-273-8090 and the letter code is the first letter of your C.D.S. registration number.

If we can be of further assistance, please call 973-504-6351 or contact us via e-mail at: askconsumeraffairs@lps.state.nj.us.

New Jersey Office of the Attorney General

Drug Control Unit
P.O. Box 45045
Newark, NJ 07101

Reinstatement Application for Registration for Dispenser/Prescriber Mid-Level Practitioner

New Jersey Controlled Dangerous Substances Act
N.J.S.A. 24:21-1 et seq.

Please type or print firmly with a ballpoint pen.

Section A: All of the items in this section must be completed.

1. Provide the applicant's name and the place of business (or, if unavailable, the New Jersey residence) to be registered (do not use solely a P.O. box). **Registration will be provided for New Jersey locations only.** If the registration is for a University of Medicine and Dentistry of New Jersey facility, include the department, room number, designation, e.g. M.E.B., M.S.B., etc. The address of record must be your practice location.

_____
Last name First name MI
C.D.S. – Responsible Individual

_____
Department Room number

_____
Street address

_____ New Jersey _____
City ZIP code

_____ _____
Home telephone number (include area code) Business telephone number (include area code)

Note: ***Please note that the above-registered address is subject to inspection pursuant to N.J.S.A. 24:21-31 & 32.***

2. Reinstatement fee: See instruction sheet for fees.

3. Registration requested for: ☐ Schedules II through V

If registration is being requested for only certain Schedules, please indicate which Schedules: ☐ II ☐ III ☐ IV ☐ V

4. (a) Has any restriction been imposed which would affect your privilege to hold a controlled dangerous substances (C.D.S.) registration for Schedule II, III, IV or V substances in New Jersey, any other state, the District of Columbia or in any other jurisdiction?* ☐ Yes ☐ No

(b) Have you been arrested, indicted or convicted of a crime in connection with controlled substances under federal law or the laws of New Jersey, any other state, the District of Columbia or any other jurisdiction?* ☐ Yes ☐ No

(c) Have you ever surrendered a controlled drug registration or had a controlled drug registration revoked, suspended or denied in New Jersey, any other state, the District of Columbia or in any other jurisdiction?* ☐ Yes ☐ No

(d) Are there any criminal charges now pending against you in New Jersey, any other state, the District of Columbia or in any other jurisdiction?* ☐ Yes ☐ No

(e) Are you aware of any action now pending against your professional license, or have you been permitted to surrender or otherwise relinquish your professional license to avoid an inquiry or investigation in New Jersey, any other state, the District of Columbia or in any other jurisdiction?* ☐ Yes ☐ No

*** If "Yes," attach a letter setting forth the circumstances of such action.**

Section B: Dispenser/Prescriber (check category)

☐ A.P.N. (Advanced Practice Nurse)
☐ C.N.M. (Certified Nurse Midwife)
☐ P.A. (Physician Assistant)

C.D.S. registration number _____

Federal N.J. D.E.A. number _____

Section C: Dispenser/Prescriber Identifying Data

1. New Jersey license number _____
(Must have an active/current N.J. license number and C.N.M.'s must include prescriptive authority suffix.)

2. Mid-Level practitioners are required to collaborate with and/or be supervised by physicians, consistent with agreed upon parameters of their respective practices. As concerns the prescribing and/or ordering/dispensing of C.D.S., by affixing my signature below, I affirm that required oversight regarding C.D.S. exists between me and a duly authorized active New Jersey physician licensee. I understand that any C.D.S. ordering/dispensing/prescribing without the required collaborative or supervisory oversight, or engaging in any violation of the statutes or regulations regarding the ordering/dispensing/prescribing of C.D.S. may be deemed professional misconduct or grounds for disciplinary sanction within the meaning of N.J.S.A. 45:1-21.

_____
Applicant's signature

3. *Social Security Number: _____-_____-_____

You **must** disclose your Social Security number for the reasons stated below. Failure to do so may result in a denial of licensure or certification or license or certificate renewal.

*Pursuant to N.J.S.A. 2A:17-56.44e of the New Jersey child support enforcement law, N.J.S.A. 54:50-25 of the New Jersey taxation law and Section 1128 E(b)(2)A of the Social Security Act, the Unit or licensing agency to which this form is submitted is required to obtain your Social Security number. If you do not have a Social Security number, the Unit must ascertain the reason that you do not have one. The Unit is further obligated to provide your Social Security number to the Director of Taxation, the Probation Division or other agency responsible for child support enforcement and the H.I.P. Data Bank when reporting adverse actions.

You are also being asked to consent, on a voluntary basis, to the use of your Social Security number for the additional reasons stated below.

You are notified that under the Federal Privacy Act (5 U.S.C. Section 552a (note (b)), the Unit or licensing agency to which this form is submitted is requesting the voluntary disclosure of your Social Security number. If you give your consent for the use of your Social Security number, it may be used: to verify the identity of an applicant, to aid in the collection of financial obligations due and owing the Unit or any other state agency, and to aid in the disclosure to state or federal law enforcement and licensing officials and agencies of information obtained in investigations pertaining to licensure or certification and disciplinary proceedings.

I, _____ , ☐ Consent ☐ Do Not Consent
Applicant's signature

to the use of my Social Security number for any of the additional purposes set forth above. I understand that my consent is voluntary and that if I do not consent, no adverse action or inference will be taken or drawn.

Section D: Affidavit - To be executed before a notary public

State of New Jersey County of _____

I, _____ being duly sworn, depose and say under penalty of false statement, that I am the person described and identified in this application; that the information given in this application and all submitted materials contain no willful misrepresentations and that the information is true and complete. I understand that should an investigation at any time disclose otherwise, my application may be rejected, and I may face legal sanctions if I am already registered. I understand that in signing this application for registration, I am consenting to any reasonable inquiry that may be necessary to verify the information that I have provided on this form or may provide in conjunction with this application.

_____
Signature of applicant

Sworn and subscribed to before me

this _____ day of _____, 2 _____. Affix seal here

_____
Signature of notary public

Retain a copy for your records. Mail the original and one copy with your fee to the above address.

DDC-35
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